STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

April 3, 2009

GENERAL LETTER NO. 8-G-42

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter G, ***CASE MANAGEMENT***; pages 1 through 6, revised.

Summary

This chapter is revised to clarify that a client who provides a signed release to a specific individual or organization for specific information has met the requirements for supplying requested information or verification.:

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter G, and destroy them:

Page	Date
1	December 12, 2000
2-4	August 3, 2007
5, 6	December 12, 2000

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

OVERVIEW

This chapter covers policies relating to how to handle changes involving active Medicaid cases.

The first section deals with the client's responsibility to report changes in household circumstances and worker actions based on the information received about changes. Reported changes may result in reinstatement or automatic redetermination, which are topics that follow the discussion on changes.

The next two sections relate to specific FMAP-related and SSI-related case maintenance issues. Reporting fraud or misuse of Medicaid services by clients or providers comprises the final section of the chapter.

CLIENT REPORTING REQUIREMENTS

Client reporting requirements include:

- Supplying requested information or verification.
- Reporting changes.

NOTE: "Clients" include applicants, members, people who are conditionally eligible, and people whose income or assets are considered in determining eligibility for an applicant or member.

All clients are responsible for reporting changes timely as they occur. However, the specific changes required to be reported and the time frames within which they must be reported may differ depending on whether the member receives SSI-related or FMAP-related Medicaid. The following sections explain requirements for:

- Supplying information and verification.
- Reporting changes.

Supplying Information and Verification

Legal reference: 42 CFR 435.916, 441 IAC 76.2(249A)

The client must supply complete and accurate information needed to establish ongoing eligibility. If you need additional information, give, mail, or fax a written request to the client. Inform the client in writing of the date the information is due and the consequences for failure to supply the information or verification.

The client must supply the information within ten calendar days of the day you give or mail a written request to the client. The ten-day period begins with the day after you issue the written request. When the tenth day falls on a nonworking day or a legal holiday, extend the due date to the next working day for which there is regular mail service.

"Supply" means the Department receives the requested information or verification by the specified date. You can allow additional time when the client is making every effort to obtain the information but is unable to do so in ten days and notifies you about the problem.

See 1-C-Appendix for a list of release forms to use when obtaining information from a third party. Explain the following to the member, in writing:

- When the client must obtain information from a third party, it is the client's responsibility to return the information timely. It is not the responsibility of the third party.
- It is the client's responsibility to follow up with the third party before the due date to make sure the third party will have the information ready to pick up or has mailed the information in time to be received by the Department by the due date.
- The client may ask for more time to get the information to the Department if the third party does not have the information ready or it will not arrive by the due date.

Although it is the client's responsibility to provide information, do not cancel assistance if the client is unable to get the information because of a disability, lack of education, or lack of knowledge. If requested, assist the client in getting information to establish continuing eligibility.

A client who provides a signed release to a specific individual or organization for specific information has met the requirement for supplying requested information or verification. The general release does not meet this requirement unless the client asks for help.

Cancel or deny Medicaid if the client fails to supply the information or refuses to authorize you to obtain it from other sources when the client is unable to obtain the information.

If the client is unable to get information from a spouse who is no longer in the household, do not cancel the case. Contact the client to obtain the best information available. Ask the client about bank accounts, records showing deposits of the spouse's income, information from the divorce proceedings, and tax returns.

Ask the client to provide information that would help to verify what the client is telling you about the spouse who is no longer in the home. Determine eligibility from the information provided. If the member fails to provide the requested information, cancel the case.

Reporting Changes

Legal reference: 42 CFR 435.916(b) and (c);
441 IAC 75.4(3)"c," 75.57(1), 75.57(2), and 76.10(249A)

The client or someone acting on the client's behalf must report the following and any other changes that affect eligibility:

- Changes in household membership.
- Medical or health insurance starting, changing, or ending.
- A change in mailing or living address. Remember to offer *Voter Registration* forms when a client reports a change of address, either in person or by phone. Ask clients reporting an address change, "If you are not registered to vote where you live now, would you like to apply today to register to vote?" Send the *Voter Registration* form if the client wants to register.
- Filing of an insurance claim against a possible liable third party with the expectation of seeking restitution or payment of medical expenses that resulted from an injury and were paid by Medicaid.
- Retaining an attorney with the expectation of seeking restitution for an injury from a possible liable third party when Medicaid has paid the resulting medical expenses.
- The receipt of a partial or total settlement for payment from a liable third party of medical expenses due to an injury which were paid by Medicaid.

FMAP-related clients must also report beginning or ending income of a client. This includes:

- The receipt of non-recurring lump sum income.
- The continuing receipt of recurring lump sum income in irregular amounts.
- Beginning to receive recurring lump sum income from a source from which another type of income is currently being received.

See 8-E, Recurring Lump Sum, for more information.

Clients who are **not FMAP-related** must also report:

- Receipt of resources by a client.
- Changes in income of a client
- Receipt of a social security number.
- Becoming incapacitated or disabled or recovering from incapacity or disability.

SSI-related clients and **members eligible for Medically Needy** must also report:

- Unmet medical bills.
- A change in health insurance premium expense, including completion of buy-in.

Members receiving **home- and community-based services** must also report residency in a medical institution for other than respite care for more than 15 days.

Clients may report changes in person, by telephone, or by mail. Give clients form 470-0499, *Ten-Day Report of Change*:

- At the time of review.
- When requested by the client.
- When the client submits the form to the local office and needs a new one.

Members and people being added to the existing eligible group must report changes within ten calendar days of the day the change occurred. If the last day to report a change is a nonworking day, the person must report the change by the next working day.

Act on changes and complete a redetermination within ten days of when you become aware of a change or when you verified the change, if verification is appropriate.

When the client reports changes in health insurance, send form 470-2826, *Insurance Questionnaire*, to the client to fill out and return. When the client reports filing an insurance claim, retaining an attorney, or receipt of a settlement, notify the Iowa Medicaid Enterprise Lien Recovery Unit at 1-888-543-6742.

When a probable change affects eligibility, act on the change if you have all information you need to establish eligibility, and the best information available indicates that the change will actually take place as reported. See 8-A, Notification, for timely notice requirements. See AUTOMATIC REDETERMINATION.

Establish a claim for any medical assistance that was incorrectly paid when a change affecting eligibility was not reported timely.

CHANGES IN HOUSEHOLD CIRCUMSTANCES

Legal reference: 441 IAC 76.10(5); 42 CFR 435.120, 42 CFR 435.919

After assistance has been approved, changes occurring during a month are effective the first day of the next calendar month, provided timely notice can be given. When timely notice is required and cannot be given, the effective date is the first day of the second month following the month the change was reported. For exceptions to this policy, see 8-F, Transitional Medicaid.

The following sections explain procedures that apply to all Medicaid households for acting on:

- Changes received through IEVS.
- Changes received from other sources.
- The death of a member.

When you become aware of unreported information, the date you receive a signed release for specific information from the member or the date the member otherwise acknowledges the previously unreported information is the date the member reports the change.

Do not cancel or deny anyone's Medicaid due to a failure to supply information about a change in circumstances that does not affect a person's eligibility.

> Mrs. R and her three children receive Medicaid under FMAP. The youngest is receiving Medicaid as a newborn child of a Medicaid eligible mother. Mr. R, the father of all three children, returns home and has earnings.
>
> The worker requests income verification and the information is not returned by the due date. The worker cancels the Medicaid for failure to return requested information. However, because income would affect neither the newborn's eligibility nor Mrs. R's eligibility if she were pregnant, the newborn's Medicaid is not canceled.

See also ADDITIONAL FMAP-RELATED CASE MAINTENANCE: Adding a New Member to an Existing FMAP-Related Case and Other Changes in the Household, for additional procedures specific to FMAP-related households.

Changes Reported From IEVS and Other Automated Sources

Legal reference: 42 CFR 435.945, 435.948, 435.955, 441 IAC 75.57(9) & 76.12

In addition to changes reported by the household, information that might affect eligibility is also available from reports generated through the Income and Eligibility Verification System (IEVS) and other sources. Check the description of each report that follows in this section and see 14-B(4), 14-E, and 14-G for more details.

When you receive IEVS information, act on the report as follows:

1. Determine if the client reported the information and if you have already acted on it. If so, note and date this on the IEVS report and file it in the case record.

   Exception: Do not file the *Earnings and Pension Report*, S470X425-A, or the *Internal Revenue Service Report*, S470X615-A, in the case record. If you have already acted on the information in these reports, note and date this in a narrative in the case record.

2. Act on information received from IEVS that was not previously reported by the household within 30 days from the date printed on the report. Check the description of each report to see whether the information must be verified or is already considered verified.

   If the new information requires verification, contact the household in writing and obtain a specific release of information, if necessary. You may delay action beyond 30 days when a third party causes the delay by not providing requested verification. It may be necessary to reduce or cancel future benefits and to establish a claim.

3. If the income does not affect past, current, or future eligibility, note this on the IEVS report, date it, and file it in the case record.

   Exception: Do not file the *Earnings and Pension Report*, S470X425-A, or the *Internal Revenue Service Report*, S470X615-A, in the case record. If the income on these reports does not affect past, current, or future eligibility, note and date this in a narrative in the case record.

4. If the IEVS information affects eligibility, do an automatic redetermination and adjust future benefits. Do a claim if necessary.